06/01/22 Morning Report with @CPSolvers

***Case Presenter**: Steph (@StephVSherman) **Case Discussants**: Zaven (@sargsyanz) and the chat <3*

CC: 2 week leg ulcer

HPI: 28yo W - 3 years ago p/w with chest pain and rash. She was told she might have SLE. Never been on therapy. Over the last 2 years, R>L leg swelling on and off . When the swell occurs, she has groin lymphadenopathy. When the swelling goes off, so does the lymphadenopathy.
Over the last month, R leg pretty swollen. Last 2 weeks with first episode of painful ulcer in the chin. Came to the ED for evaluation.

PMH:
none

Meds:
none

Fam Hx:
Non contributory

Soc Hx:
4yo healthy child
Works in an office

Health-Related Behaviors:
Non contributory

Allergies:
None

Vitals: **T**: **nl HR**: **nl BP**: **nl RR**: **nlSpO_2**: nl
Exam:
Gen: well-appearing
HEENT: nl **CV**: nl **Pulm**: nl **Abd:** nl
Extremities/Skin: R>L pitting edema ("puffy")
R shin - 4 cm well-circumscribed tender necrotic ulcer with black eschar

Notable Labs & Imaging:
Hematology:
WBC: nl Hgb: 7.5 (low MCV 62) Plt: nl
Iron deficiency anemia

Chemistry:
BMP - unremarkable HIV neg
Urinalysis - 30 mg/dl protein, no RBCs.
PTT: 39 (corrected with mixing study) Normal INR
Leg US - no clots
ESR >100 CRP 13
Cr nl BUN nl
Heavy menstrual bleeding Positive ANA
Biopsy - reactive lymphadenopathy with normal cytometry
2 transient face and lips swelling episodes - 4 years ago - never happened again
Hb electrophoresis - nl
CT venography - no compression / diffuse bony sclerotic lesions
Plan film leg - diffuse sclerosis lesions
CXR nl

Problem Representation: 28yoW with a PMH significant for suspicious SLE p/w 2 weeks R leg ulcer and edema. Found to have tender necrotic ulcer with black eschar and labs consistent w/ IDA and elevated ESR and CRP. Plan film of the leg revealed diffuse sclerotic lesions.

Teaching Points (Seyma & Kirtan):

- **Leg Ulcers:** Vascular (Art/Venous/Vasculitis), Infection, Malignancy, Autoimmune (PAN, Lupus, Sarcoid, SVV, APLAS or pyoderma gangrenosum)
  - Varicose veins predispose to vascular ulcers w/ unilateral edema
- **Unilateral leg edema**: venous insufficiency, lymph edema (e.g. elephantiasis due to filariasis), lymphangitis, cellulitis, DVT, ruptured baker's cyst, pelvic neoplasm ;usually not a/w LAD (reactive?)
  - May Thurner Anomaly/Cockett syndrome: L Iliac vein compressed by R iliac artery
- **Black eschar:**
  - Infection: rickettsia, scrub typhus, anthrax, tuleremia, fungal; calciphylaxis (uremic calcific arteriolopathy) or ecthyma gangrenosum (sepsis w/ pseudomonas aeruginosa), gas gangrene
- Vasculitides:
  - **Medium vessel**: nodules, ulcers; **Small-vessel:** petechiae, palpable purpura
- Neutrophilic dermatoses: Sweet, Pyoderma g. → initially rather erythematous, then ulcerate
- **Microcytic anemia:** iron-def (menstruation, etc), Hb-pathies (sickle-cell disease),
  - **Mentzer-Index:** RBC/MCV-Index (>13 → rather iron deficiency mediated anemia; <13 ß-thalassemia)
  - **"TAILS"** Mnemonic for microcytic anemia: **T**halassemia, **A**nemia of chronic dz, **I**ron deficiency, **L**ead poisoning, **S**ideroblastic
- >50% pyoderma gangrenosum: idiopathic; otherwise a/w autoimmune, sarcoid
- **Isolated elevated PTT:** think of APLS
- **Sclerotic bone lesions:** malignancy (multiple myeloma, metastases: prostate-cancer, infiltrative (Langerhans cell histiocytosis, Gaucher's dz, Erdheim Chester) Autoinflammatory dz (Schnitzler), Mastocytosis, POEMS, metabolic (Paget's dz)
- >90% of patients w/ sarcoid should have an abnormal Chest CT scan (LAD, …)